REFERENCE D: BENEFICIARY ADMISSION QUESTIONNAIRE

The following questionnaire contains questions that the provider should ask Medicare beneficiaries upon each inpatient and outpatient admission. Providers can use this questionnaire to help identify other payers that may be primary to Medicare. Beginning with Part 1, providers should ask the patient each question in sequence and comply with any follow-up instructions that pertain to an answer provided by the beneficiary. If the instructions direct the provider to proceed to another part of the questionnaire, the provider should have the patient answer, in sequence, each question within that subsequent section of the questionnaire.

Part I:

1. Are you receiving Black Lung Benefits?

   ☐ Yes; Date benefits began: _____ (in YYYY|MM|DD format)

   IF YES, BLACK LUNG BENEFIT IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO BLACK LUNG.

   ☐ No

2. Are the services to be paid by a government program such as a research grant?

   ☐ Yes

   IF YES, A GOVERNMENT PROGRAM WILL PAY PRIMARY BENEFITS FOR THESE SERVICES.

   ☐ No

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

   ☐ Yes

   IF YES, THE DVA IS PRIMARY PAYER FOR THESE SERVICES.

   ☐ No

4. Was the illness/injury due to a work-related accident/condition?

   ☐ Yes; Date of injury/illness _____ (in YYYY|MM|DD format)

   Name and address of Workers' Compensation (WC) Plan:
   _____
   _____
   _____
   _____

Policy or Identification Number _____

Name and address of the employer

_____
_____
_____
_____

IF YES, WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK-RELATED INJURIES OR ILLNESS. PROCEED TO PART III.

☐ No

IF NO, PROCEED TO PART II.

Part II:

1. Was illness/injury due to a non-work related accident?

☐ Yes; Date of accident _____ (in YYYY|MM|DD format)

☐ No

IF NO, PROCEED TO PART III.

2. What type of accident caused the illness/injury?

☐ Automobile

☐ Non-automobile

Name and address of no-fault or liability insurer

_____
_____
_____
_____

Insurance Claim Number _____

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. PROCEED TO PART III.

☐ Other

3. Was another party responsible for this accident?

☐ Yes;

Name and address of any liability insurer

_____
_____
_____
_____

Insurance claim number _____

LIABILITY INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. PROCEED TO PART III.

☐ No

PROCEED TO PART III.

Part III:

1. Are you entitled to Medicare based on:

☐ Age

PROCEED TO PART IV.

☐ Disability

PROCEED TO PART V.

☐ ESRD

PROCEED TO PART VI.

Part IV - Age:

1. Are you currently employed?

☐ Yes

Name and address of your employer:

_____
_____
_____
_____

☐ No; Date of retirement _____ (in YYYY|MM|DD format)

2. Is your spouse currently employed?

☐ Yes

Name and address of spouse's employer:

_____
_____
_____
_____

☐ No; Date of retirement: _____ (in YYYY|MM|DD format)

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2 ABOVE, MEDICARE IS PRIMARY PAYER. IF THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II, MEDICARE IS NOT PRIMARY PAYER. DO NOT PROCEED FURTHER.

3. Do you have Group Health Plan (GHP) coverage based on your own, or a spouse's current employment?

☐ Yes

☐ No

IF NO, STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.

4. Does the employer that sponsors your Group Health Plan (GHP) employ 20 or more employees?

☐ Yes

IF YES, STOP. GHP IS PRIMARY PAYER. OBTAIN THE FOLLOWING INFORMATION:

Name and address of GHP:

_____
_____
_____
_____

Policy identification number: _____

Group identification number: _____

Name of policyholder: _____

Relationship to patient: _____

☐ No

IF NO, STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.

Part V - Disability:

1. Are you currently employed?

   ☐ Yes

   Name and address of your employer:

   _____
   _____
   _____
   _____

   ☐ No; Date of retirement: _____ (in YYYY|MM|DD format)

2. Is a family member currently employed?

   ☐ Yes

   Name and address of your employer:

   _____
   _____
   _____
   _____

   ☐ No

   IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2 ABOVE, MEDICARE IS PRIMARY PAYER, UNLESS THE PATIENT ANSWERED YES TO BOTH QUESTIONS 1 AND 2 IN PARTS I AND II. DO NOT PROCEED FURTHER.

3. Do you have Group Health Plan (GHP) coverage based on your own, or a family member's, current employment?

   ☐ Yes

   ☐ No

   IF NO, STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.

4. Does the employer that sponsors your Group Health Plan (GHP) employ 100 or more employees?

   ☐ Yes

   IF YES, STOP. GHP IS PRIMARY PAYER. OBTAIN THE FOLLOWING INFORMATION:

Name and address of GHP:

_____
_____
_____
_____

Policy identification number: _____

Group identification number: _____

Name of policyholder: _____

Relationship to patient: _____

☐ No

IF NO, STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.

Part VI - ESRD:

1. Do you have Group Health Plan (GHP) coverage?

☐ Yes

Name and address of GHP:

_____
_____
_____
_____

Policy Identification Number: _____

Group Identification Number: _____

Name of policyholder: _____

Relationship to patient: _____

Name and address of employer, if any, from which you receive GHP coverage:

_____
_____
_____
_____

☐ No

IF NO, STOP. MEDICARE IS PRIMARY PAYER.

2. Have you received a kidney transplant?

   ☐ Yes; Date of transplant: _____ (in YYYY|MM|DD format)

   ☐ No

3. Have you received maintenance dialysis treatments?

   ☐ Yes; Date dialysis began: _____ (in YYYY|MM|DD format)

   If you participated in a self-dialysis training program, provide date training started: _____ (in YYYY|MM|DD format)

   ☐ No

4. Are you within the 30-month coordination period?

   ☐ Yes

   ☐ No

   IF NO, STOP. MEDICARE IS PRIMARY PAYER.

5. Are you entitled to Medicare on the basis of either end-stage renal disease (ESRD) and age or ESRD and disability?

   ☐ Yes

   ☐ No

   IF NO, STOP. GROUP HEALTH PLAN (GHP) IS PRIMARY PAYER DURING THE 30-MONTH COORDINATION PERIOD.

6. Are you entitled to Medicare on the basis of either end-stage renal disease and age (ESRD) or ESRD and disability?

   ☐ Yes

   IF YES, STOP. GROUP HEALTH PLAN (GHP) CONTINUES TO BE PRIMARY PAYER DURING THE 30-MONTH COORDINATION PERIOD.

   ☐ No

   INITIAL ENTITLEMENT IS BASED ON AGE OR DISABILITY.

7. Does the working aged or disability Medicare Secondary Payer (MSP) provision apply (i.e., is the Group Health Plan (GHP) primarily based on age or disability entitlement)?

☐ Yes

IF YES, STOP. GHP CONTINUES AS PRIMARY PAYER DURING THE 30-MONTH COORDINATION PERIOD.

☐ No

IF NO, MEDICARE CONTINUES AS PRIMARY PAYER.

If no MSP data are found in the Common Working File (CWF) for the beneficiary, the provider still asks the questions and provides any MSP information on the bill using the proper uniform billing codes. This information will then be used to update the CWF through the billing process.